PRACTICAL MANAGEMENT OF MEDICAL LIABILITY FOR CARDIAC ERRORS IN A HOSPITAL ENVIRONMENT

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Medical liability is likely to continue to be a real problem for the medical profession during the next 10 years. Thus, it is necessary for all of us to have at least the basic legal knowledge to face potentially difficult situations with patients who have suffered a genuine medical problem or those who believe they have.

MAIN RULES FOR MEDICAL LIABILITY

Hospital liability is different from business liability

In contrast to French laws, which have followed the principle of contractual liability since 1936, and American laws, which use a combination of delictual (violation of law) and contractual liability,[1] English medical liability is based purely on the common law principles of liability*. The practitioner will be prosecuted if he causes an involuntary injury through negligence. Negligence occurs when the standard of care is not met, the standard of care being defined as ''the standard of the ordinary skilled man exercising and professing to have that special skill... it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art'' (Bolam v. Friem Hospital Management Committee, 1957). Thus, if the practitioner can demonstrate that the standard of care was met he is not liable for the patient's injuries.[2–4]

Liability is not, however, limited to personal liability: employers can be held responsible for their employees' actions.

The plaintiff will have to prove the causal link between his injury and the practitioner's actions or failure to act. Thus, filing a lawsuit against a practitioner presupposes the association of a medical error, an injury and a causal link between the above—that is, that the error caused the injury and the injury would not have occurred otherwise.[2]

On the other hand, if there is a clear error, it is the responsibility of the practitioner to prove he was not at fault.

If a patient does not agree with the treatment he received, he can make his complaint orally or in writing in order to obtain explanations (National Health Service claim proceeding, 1996).[2 5]

We all know that medicine is an art as well as a science, and that conflicts can arise between patients and doctors. Under these conditions, we need to be well informed, and avoid saying inappropriate things to patients or families, or displaying inappropriate attitudes. Moreover, we need to be able to identify situations that could generate complications. Mistakes can arise as a result of problems in the organisation of the care unit, but may also be personal faults.[6–8]

Types of errors

The circumstances that can lead to conflicts are varied and conflicts can be the result of a medical issue or a question of attitude. In fact, several circumstances can increase the risk of mistakes happening—for example, forgetting to take kidney disease into consideration, or drug dose or associated errors, both of which can cause toxic accumulation as well as side effects, especially in the case of β blockers and antiarrhythmic drugs which have been known to cause severe bradycardia and impairment of systolic function.

Possible errors can also take the form of physical injuries, whether they occur during stress testing, transoesophageal echocardiography or coronary angiography, or concern side effects of treatment without any fault through lack of information, or complications due to these side effects.

The way in which information is presented and explained to a patient can affect greatly patient's perception of the situation, whether it would be a therapeutic hazard or an actual error.

When it comes to dealing with the complications themselves, the quality of the contact between the patient and the medical team is fundamental.

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*We say ''English rules'' and not ''British rules'' as Scottish rules are very similar to the French principles of liability. From Moreteau. Droit anglais, particularisme et union européenne, *Gazette du Palais*, 15–16 December 1995.

Thus, as well as establishing the cardiological situations which are known to be associated with an increased frequency of complications, we must also identify situations where errors are likely to arise or which may alter the patient's attitude and lead to conflict

The list of potential errors is large and it is necessary to identify the conditions that are conducive to errors.[9] They can concern an insufficient examination and monitoring of the patient, as well as insufficient monitoring of the work done by interns or nurses regarding this patient. Furthermore, errors can also be a question of competency and the quality of the intervention itself, such as when a practitioner attempts to perform a procedure he is not trained to do or experienced in doing, especially in the case of medical examinations requiring a special skill—for example, transoesophageal echocardiography or coronary angiography. This is even more of a problem if patients are in general poorly managed. In our cardiology departments, the staff rota can be an immense source of problems, in particular with staff shortages when it is difficult to find someone to cover every shift. The rota becomes even more problematic when a negative psychological atmosphere is present in the department.

Some other situations which should be accompanied by warning signs are hasty routine examination or decision-making, lack of patient consent, or lack or a deficiency of dialogue. We all know that our job is tiring and when a practitioner has to work the day shift after a sleepless night on call it is not surprising that he or she is exhausted and is more prone to making mistakes. We must, by law, retain patient files for a sufficient amount of time. We must be able to argue and to use medical evidence to defend ourselves in case of a trial. Wrong certificates written to help a patient are forbidden.[3] Unfortunately, the list goes on.

IN CASE OF TROUBLE, WHAT TO DO AND WHAT NOT TO DO?

An appointment with a claimant/patient is rarely a pleasant occasion. The practitioner may be agonising over the fact that a mistake may have caused an injury to the patient, which could have severe consequences. Furthermore, the patient in these circumstances is rarely positively disposed to the practitioner. It is always worthwhile trying to salvage the situation without recourse to the law. Here are a few proposed ''recipes'' to get through these discussions.

Always accept to meet the claimant/patient but without being ''at their beck and call''; it is logical to accede to the demand but it is not necessary to ''obey''. Never let them get the impression that you are avoiding them.

Similarly, we must let the plaintiff speak—he came to express suffering, anger or just a desire to hear an explanation. It is important that he feels able to express his views and is being listened to. It is much easier to address the issue if you know precisely for what your interlocutor is reproaching you. During this discussion, always remain courteous, and never lose your temper.[11]

It is important to go through the file point by point with the claimant, to show him the medical decisions that were taken. The claimant may be given a copy of the file, but never the original, which always remains the hospital's property. The information belongs to the patient, but the physical file belongs to the hospital. **Never dispose of it**. Go over the history of the condition with the patient, the examinations carried out, and letters sent. Remind them of what was said, and written on the file, the verbal acceptance of medical decisions, or refusal by the patient of proposed treatment or explorations (all this must be written on the file).[10]

The practitioner must have an irreproachable medical knowledge of the condition in order not to be caught out and to be able to field difficult questions.

It is imperative to establish the psychological boundaries of the relationship with the plaintiff from the outset. Thus, do not let the plaintiff be rude; never let yourself be threatened even if you feel guilty (this will set a precedent that you will acquiesce to all demands); and do express empathy but do not apologise for errors for which you are not responsible—to admit the reality of an injury and express empathy does not mean you have to admit a liability. Be very careful what you say and, above all, do not deny the facts, otherwise you will no longer be trusted.

Finally, inform your employer and insurer(s), telling them about the facts of the case and of any discussions.

Prevention is better than cure

Always conserve well kept records and keep archive material, including proof of information given to the patient and letters sent to colleagues, for a long time. Similarly, note everything in the patient's file, especially when the patient's attitude seems unorthodox towards their health—''Today… I informed the patient once again that …, he tells me …, I remind him that he didn't attend (examination), and thus informed him that he should …'' All these elements should be written on the file; however they do not constitute proof but presumption elements, which will be strengthened with a letter to the patient's general practitioner. It is important to take enough time with the patient to explain and explain again in a second appointment, if necessary, so that no point is left unclear.

However, there are some mistakes that are easily avoided.

- Never admit a fault that you are not responsible for.
- Never refuse contact with the patient, as this could be perceived as a severe lack of interest for your patient's health and demands. If you do, the wheels will be set in motion without you, which may well be to your disadvantage.[7 11]
- Do not be accompanied straight away by a medical colleague. The plaintiff may be aggressive or frightened and this may put him on the defensive even more.
- You must at all times show a proper standard of behaviour. Never display inappropriate or unjustified attitudes. Never cover up for a colleague or an assistant in an inappropriate way or bring evidence against a colleague or an assistant, even if you think they are responsible for a severe fault. Despite the confrontational nature of this meeting, never try to disconcert your interlocutor and above all never be disconcerted by him. Never shout, even to be heard if the other person does. Instead conclude: ''We must be constructive. In order to answer your questions, you have to let me speak. If you do not, this appointment has no reason to continue and I will be forced to terminate it.''

If we had to draw an outline of the best position to take in these unpleasant situations, we could describe this as:

- Correct, honest, courteous, self assured and competent, but not arrogant
- Sympathetic, but remember you are not responsible for faults you did not commit
- Always try to calm any ruffled feathers but never admit liability, even if you feel you are in the wrong.

The aim is not ''to be right at any price'', but to move the claimant/patient to consider that his claim may not be justified.

And never forget that ''Un mauvais accord vaut mieux qu'un bon procès'' (Georges Bernard, lawyer, Paris Law Court).

CONCLUSION

Before judiciary action, expert appointment and trial, reception of a claimant or family can be a very hard experience. However it may be the last opportunity to avoid conflict and to re-establish a peaceful dialogue. Here we have analysed the circumstances which may arise and how best to deal with them. To prevent these situations from occurring it is essential to follow ground rules that are based on sound medical judgement, common sense, good manners, and recent legal cases. To conclude, in order to avoid some nasty situations, the whole medical body should have a minimum understanding of medical liability laws.

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